MONTEFIORE HOSPITAL, 1884-1984: HISTORY, HEALTH CARE AND SOCIETY

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PERHAPS the most frequent cliche in discussions of the education of physicians is that since implementation of the Flexner Report the emphasis of that education has been too heavily on the sciences. A frequent corollary of that argument is the need to develop compassion in physicians. The humanities are often invoked as possible agents in the operation. While there is no particularly logical connection between a knowledge of fine arts or literature or history and a desire to serve humanity, there is a need to show students that medical questions are complex and that disciplines other than science can illuminate problems and assist physicians in decision making. Science is basically ahistorical, forever declaring: "This is truth," omitting the necessary qualifier: "This is today's truth." An exposure to historical development, to yesterday's struggle to see dim outlines, can develop both skepticism and respect for the difficulties of the quest.

We are living in a period when the subject matter considered appropriate for medical history is undergoing an expansion. There is growing interest not only in the development of scientific medicine rather narrowly defined but in the growth of institutions and their relationships with society. At the same time an intense contemporary debate about bioethical issues has evoked an interest in the historical background, the methods by which such problems were resolved in the past.

Medicine in the United States suffers not so much from a lack of compassion on the part of individual practitioners as from institutionalized callousness: patients are deprived of care because they do not have insurance; the elderly suffer because most nursing homes are badly run. A history of how these arrangements came to be can stimulate students to a realization that they can be changed.

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The November 1984 issue of the *Bulletin of the New York Academy of Medicine* was devoted to a series of articles dealing with aspects of the history of medicine. Both the title selected for the issue, "A Medical History Miscellany," with its suggestion of Victorian nostalgia and the variety of the articles, were representative of the idiosyncratic view of the past that the discipline has often presented.

Medical history has traditionally been taught in one of two ways: as a subject of antiquarian interest with an emphasis on the works of Galen or Vesalius or as a celebration of the lives of great men, especially of Osler, Halsted and Welch. During the last few years there has been a greater concern with the interaction between society and medicine, and there have been some interesting studies of particular agencies and their work, usually from a highly critical point of view, e.g., *Rockefeller Medicine Men*[1] or *Bad Blood*.[2] In spite of Paul Starr,[3] we still lack a full-scale study of how the interaction among science, social need, economics, morality and ambition led to the creation of the modern health care system, or any method to insure that any knowledge of that process is included in the training of the average physician.

Teaching hospitals have traditionally accepted the responsibility for much of the research carried on in the name of medicine as well as for much of the teaching of physicians and other professionals. One area of subject matter, either as teaching or research, in which hospitals have rarely made a considerable commitment of resources is that of the history of medicine.

The Johns Hopkins Medical History Club was actually organized at the hospital three years before the medical school opened.[4] A brave beginning, but at Hopkins the subject soon became the teaching prerogative of the medical school and most serious activity in the discipline there and at other medical centers since then has occurred within the groves of academe. Occasionally a hospital has been blessed, as was Mount Sinai in New York with Albert Lyons,[5] by an enthusiast who has kept alive the idea of the history of medicine, although not especially focussed on the history of that insitution. An occasional hospital has cared for its own records. New York Hospital, with the assistance of the Josiah Macy Foundation, has created a magnificent archival collection, magnificently housed. Massachusetts General Hospital has produced a continuing history,[6] a volume appearing every few years. Most hospitals have been concerned with their own history only when some anniversary rolls around and a decision is made to issue a celebratory volume. These self-generated histories have not usually related the story of a particular institution to the general history of medicine or to the history

of the society in which the hospital has functioned, nor have they attempted to draw general conclusions about the development of hospitals. In recent years there have been objective histories of groups of hospitals written by historians or sociologists unconnected with any particular institution such as David Rosner's *A Once Charitable Enterprise*[7] or Morris Vogel's *The Invention of the Modern Hospital, Boston 1870–1930.*[8]

Hospitals are central to the history of modern medicine because, for the last hundred years, they have been the scene of the action: the places where the scientific discoveries have been implemented, where physicians have learned their trade, where societies have learned how to put into practice that newly accepted notion of public responsibility for the care of those who are sick or who are entering or leaving this world. The records of those struggles are in the hospital files. The medical records rooms, the collections of published papers, the minutes of the boards of trustees and innumerable other documents provide researchers with the special pleasure of working with primary sources and deciphering the meaning of the footsteps in the solidified mud.

At Montefiore Medical Center the decision to embark on a study of institutional history was made as the one hundredth anniversary of the founding in 1884 approached. The result was not merely celebration but a serious look at the past in the hope of understanding the present and planning usefully for the future.

The first task was collection of the evidence. No consistent or systematized efforts had been made to gather, preserve or catalogue the old records. Considerable time in the early months was spent exploring attics, basements and storerooms. Use was made of an in-house publication to notify as many people as possible of the search and to enlist help. A letter was sent to each member of the staff and alumni association asking for reminiscences, papers, photographs, etc. A start was made taping interviews with older staff members, trustees, etc.

Gradually materials accumulated: annual reports, patient records, medical board minutes, board of trustees minutes, building plans, photographs, tapes. Some of these were very like the same kinds of records in other institutions. Others differed. Patient records do not usually give many details of patient's lives. Because Montefiore began as a Home for Chronic Invalids and had the care of the chronically ill as long-term patients as a main function, until after World War II the pace of life was slow. Physicians had time to write down anything a patient cared to report. For instance, the record of a patient admitted in 1899 tells of a whole life. It begins:

L.L.
Admitted June 8, 1899
Age: 40
Occupation: Shirtmaker, painter
Nativity: Russia Sex: M
How long in U.S.? 11 years
Family history: father died at 60—mother at 40 of typhoid—one uncle was insane—5 living children, 1 dead, no miscarriages.

Previous history: was always well—bowels always regular—denies venereal history—formerly alcoholic—while on farm used to transport alcohol—never intoxicated, though would drink much—in America not alcoholic—moderate smoker—moderate sexually—never masturbated—moderate tea—worked 10 hours a day. Since one year a painter of fixtures, tin or iron. Present illness dates back 2 years—Cause interrupted coitus or shirtmaking by machine. Began with pains in especially left lower extremity. Point of maximum intensity was instep and pain extended from above knee downward—had to walk with a cane—this lasted two weeks and was bettered by walking in wet grass. Went to work on farm for three months. Then after working two months again at machine at 2 am would wake with a start and so would sleep only four hours a night; at same time headache. Left machine and went to painting for five months—felt well and slept well, then factory burnt down and received a great shock because he had a family to support and no work—became nightwatchman and was severely frightened one night. Then began to get bad and gloomy thoughts, very much depressed, severe headaches (frontal); from then on sick—would return from work completely exhausted. Then saw Dr. Abrahamson at Postgraduate—since then much worse—cannot sleep—very gloomy, depressed; was told that his wife would not live with him any more and this makes him sad. Has noticed himself a change in his wife's demeanor toward him—does not imagine her faithless at present but perhaps anxious to be rid of him or divorce him. He appreciates that he talks too much, is too restless but asserts that if he would have a good night's sleep would be all right. Asserts that, after repeated questioning, he had been punished by God for working on Saturdays, though compelled to by employer through threat of dismissal—perhaps it is a deserved punishment, yet why was he alone selected—wife did not desire it, yet necessity prompted him.[9]

There were other records written by the patients themselves, who stayed for months or even years and from 1915 to 1928 published their own newsletter. They wrote about life in the old country, their experiences in steerage, their life in the tenements of the lower east side. They wrote about life in the hospital, their medical treatment, the doctors, the nurses, the orderlies. Letters to the editor asked for movies for the patients. Some discussed politics or philosophy.

One letter expressed only the heartfelt cries of a sick patient who wanted to be well:

> What will be for the sick people? Doctors should be happy to help sick people. And if they get well, So they will try the Hospital; If the sick people will get well, so this Hospital will have the biggest name for all the Hospitals. Here is very good doctors and good nurses. The god should help the sick poor people to get well, And after when the sick people will get well, So they could make a hotel from this place. No more Hospitals. If I will get better, I will be very thankful for my health. I am very sick and I worry for my bad sickness. My left foot hurt me, and my left hand hurt me, And also I have heart trouble. So please excuse me for my trouble.[10]

The patient records show the changes in medical treatment and the incidence of disease over 100 years. The first patient admitted to the Home suffered from tuberculosis and insanity and had a history of lead poisoning, all diseases still endemic in the population served by Montefiore. Interesting patterns reveal themselves. The hospital has always served an immigrant population. Sometimes the new groups arrived from foreign countries, sometimes from other parts of the United States. Whenever a new group arrived, the records seemed to show an increase in the number of cases of asthma, which might indicate that asthma reflects the stress of the immigrant experience.

The use of adrenalin in the treatment of asthma at Montefiore was not only one of the first therapeutic uses of the hormone, it was also the first drug treatment available there that was able to accomplish more than the relief of pain, and a proof of the value for research purposes of an institution where long-term stays made possible long-term continuous observation of patient response. In the 1920s and 30s physicians were able to track the long-term effects of insulin and diuretics.

The name of the institution changed frequently, from a Home for Chronic Invalids to a Hospital for Chronic Diseases through other variations to today's Medical Center. A close reading of modern patient records indicates that the nature of treatment has changed more than the complaints treated. The first patients suffered from heart and kidney diseases, from cancer, neurological conditions, arthritis and diabetes. The two greatest infectious diseases, tuberculosis and syphilis, have been brought under considerable control. Most of the other diseases found in the 19th century Home are still commonplace among Montefiore patients and they are still chronic conditions. The difference is that bed rest is no longer regarded as curative. The patient with any of these problems may spend years under the supervision of a physician but live at home, perhaps occasionally entering the hospital for diagnostic tests or for surgery.

Montefiore was founded at a time when modern hospitals had not yet taken shape. Nineteenth century hospitals were as concerned with charity as with medicine. They were set up by the well to do to care for the poor. The middle classes stayed at home when they were ill, cared for by family or servants. The danger of infection was too great to risk the hospital.

The story of Montefiore in its beginnings is that of the established and prosperous Jewish community attempting to care for poor Jewish immigrants. The first Jewish settlers admitted by Peter Stuyvesant were Sephardim, descendants of refugees driven from Spain after the final reconquest by "les rois catholiques." Their heirs long dominated the New York Jewish community. They founded the first Jewish hospital in New York City, Mount Sinai.

As the second half of the 19th century ran its course, Jews from the German speaking states of central Europe were financially and socially secure enough in New York City to challenge the Sephardic establishment. In 1877, more than a quarter of a century after the founding of the hospital, the president of the Reform Temple Emanu-El became president of the Mount Sinai board.

Sir Moses Montefiore, born in Italy to a Sephardic family, spent most of his life in England where he was knighted by Queen Victoria and became the most influential Jewish leader in Europe. As he approached his one hundredth birthday in 1884, Jewish communities all over the world discussed suitable ways in which to honor him. The meeting held to decide upon a memorial for New York City was held at Shearith Israel, a bastion of Sephardic ritual, but most of the prominent businessmen who attended were of German Jewish origin, most of them members of Temple Emanu-El.

There was no doubt about which group would make the decision about the memorial to Sir Moses. Not that the discussion was without acrimony. The rabbis present pushed for a home for Jewish juvenile delinquents. That thought was rejected with some apprehension that there was a degree of antisemitism in the suggestion that Jewish juvenile delinquents existed. The ultimate vote was for an institution to care for chronically ill patients for whom Mount Sinai could do no more.

The men who conducted the Home were representative of the varieties of German Jewish immigrants. The resident physician ("resident" because he lived at the Home, not because he was in training) was Ludwig Senff, recently arrived from Prussia, holder of an Iron Cross from his Emperor. The chairman of the medical staff was Simon Baruch, father of Bernard Baruch. Simon had also been born in Prussia but had fled his native land to escape

conscription in the army. He went to stay with shopkeeping relatives in Charleston, South Carolina, learned English and was in medical school in Richmond when the guns fired at Fort Sumter. Upon graduation he joined the Confederate forces as a surgeon. His newfangled notion that he should clean his instruments between amputations brought some derision but he served creditably at Gettysburg and a whole series of southern disasters.[11] After the war he married and began to raise a family. His wartime experiences made him a convinced and militant southerner. To the end of his days he embarrassed his family by leaping to his feet with the rebel yell whenever "Dixie" was heard.

During the immediate postwar period, he joined wholeheartedly in efforts to drive occupying troops from the South. He rode with Wade Hampton's Redshirts in their successful attempt to overthrow the reconstruction government of South Carolina. At one point he was simultaneously president of the local Hebrew Benevolent Association and a member of the Ku Klux Klan.

The presidential election of 1876 had a profound effect on Jews in the South. The election went to the House of Representatives and a compromise was reached whereby Rutherford B. Hayes, the Republican candidate, became president on condition that northern troops were withdrawn. The attempt at a biracial democracy in the South was abandoned, not to be resumed for almost 100 years. Organizations such as the Klan, formed to drive out the Yankees and subdue the freedmen, seeking new targets and scapegoats for economic conditions in the South, became virulently anti-Catholic and antisemitic. The Baruchs joined the exodus of Jewish families leaving the South.

Simon found himself in congenial company with the group of businessmen designing Montefiore, and this opinionated man strongly influenced the kind of institution that developed. He was a great believer in hydrotherapy, the treatment of disease by water. Almost immediately after the Home opened in a small rented house at 84th Street and Avenue A, the trustees started to raise money for a larger building. The new 230-bed Home opened in 1889 at Amsterdam Avenue and 138th Street, a spot the *New York Times* described as the "green outskirts of the city." The building was full of bath tubs and showers and whirlpools and hoses and every other apparatus to apply water to—and into—the human body.

Baruch had other theories about medical care. He mistrusted the heavy doses of drugs that were then accepted practice and scolded interns and attending physicians alike. On the other hand, he felt that the trustees were more interested in charity than in medicine; more interested in "soothing

the sighs of the dying'' than in helping them to live. He believed in active medical care, in trying to restore as many patients as possible to as high a level of functioning as possible.

It was not the physicians who ran the Home, however. Both ultimate and day to day power was with the Board of Trustees. In spite of Simon Baruch, 19th century hospitals were more charity than medicine. Most physicians had little interest in hospitals. They trained by apprenticeship to physicians in private practice. Once in practice themselves they did not admit their own patients to hospitals.

The trustees met frequently and visited often. In the archives at Montefiore is a small piece of paper on which is drawn a floor plan of the Home. Each of the 26 beds is shown and beside each bed, a name. The piece of paper belonged to one of the trustees who wanted to be able to greet each patient by name. The trustees made all the decisions. They considered and approved each admission, gave permission for each surgical operation, and disciplined staff and patients alike.

Jacob Schiff, chairman of the board for 35 years, was born in Germany to a prosperous family and came to this country to increase his fortune. Like all the trustees, Schiff looked to Germany for the best and latest in medical science. In the early years most of the attending staff and the residents were German born and trained. The records are written in English mixed with German. A patient is often reported as suffering ''heftige Schmerzen.''

In Berlin Koch had identified the bacillus responsible for tuberculosis two years before Montefiore opened. He then devoted himself to what seemed the next logical step, finding a vaccine which could either prevent or cure tuberculosis. In 1890 he announced, prematurely, that he had found a cure. The sick of Europe flocked to Berlin and Schiff immediately sent for a supply of the fluid for Montefiore. Simon Baruch was in charge of the tests. He proved to his own satisfaction that the substance was not a cure but that it was a useful diagnostic tool. (Under the name of tuberculin it is still used in diagnosis.) In 1895 Roentgen announced the discovery of x rays. Schiff immediately sent a young doctor from Montefiore to learn about this latest German discovery and to buy the equipment.

For all the emphasis on scientific medicine, the kind of institution that developed was strongly influenced by the fact that most of the patients could not be cured. Neither trustees nor physicians could believe in medical care as the sole therapy. They were forced to pay attention to other circumstances, that chronic illness disrupted the lives of patients and their families, that other

kinds of help were necessary. In 1886 a fund was set up to provide for families whose breadwinners were patients, and Montefiore early developed broad social service programs.

Physicians and trustees also became aware of the social causes of disease. The greatest killer on both sides of the Atlantic was tuberculosis. The connections with poor housing and nutrition were obvious. Trustees and physicians became involved in the public health movement. Montefiore became a place for people interested in more than the technology of medicine, for people who knew that the health of a community depended on more than access to doctors and hospitals. Simon Baruch campaigned for public bath houses. He was succeeded as chairman of the Medical Board by Bernard Sachs, who identified Tay-Sachs disease, and who also spent endless energy improving garbage collection in New York City.

Lyman Bloomingdale, a trustee, provided the money to open the first sanitarium in the New York area for poor people suffering from tuberculosis. The basic treatment, often effective in early infection, was fresh air, rest and good food. Jacob Schiff insisted that a farm be part of the sanitarium, both to provide fresh food and to train the patients in agriculture. Schiff was worried about increasing antisemitism in New York and saw a solution in encouraging discharged patients to go west.

In the earliest years many patients shared the cultural heritage of the board and physicians. German, Hebrew and English were official languages in the wards. The Home opened, however, just at the beginning of the flood tide of Jewish immigrants from eastern Europe. A new language, the Yiddish of the shtetl, was heard. The physicians called it "jargon." Jacob Schiff called the newcomers "fellow Israelites." Other trustees and physicians called them "barbarians from the east," "Russian as to nationality and tailors as to occupation." Their orthodox religion was strange to those brought up in the Reform tradition. One of the physicians visited the sanitarium and suggested that, in the interests of hygiene, the patients should shave their beards. But, he explained, "they clung to them with an almost religious fervor." Their politics were even less acceptable. Many had been involved in revolutionary activities in Russia or union organizing in the garment industries of New York. In 1903 the director of the sanitarium requested that the board discharge 10 patients because they were anarchists. One was not only an anarchist but "he threw a cup at Mr. Hatfield."

The sons of the anarchists and tailors, however, were working their way through medical school and upon graduation they were accepted at Montefiore. Much more quickly than at Mount Sinai, the numbers of eastern Eu-

ropean Jews on the staff increased. The Board retained its Teutonic character. The Board also retained power at Montefiore much longer than at most hospitals. As the possibilities of medicine increased, especially in surgery, the middle class began using hospitals. Paying patients became an important source of revenue, and physicians began to admit private patients to hospitals. Hospitals assumed their modern character as workshops for doctors, and doctors became extremely powerful in the running of hospitals. That did not happen at Montefiore because the patients could not pay their bills. They stayed for months or even years. The demands of chronic illness made them poor. Because Montefiore remained a charity supported by philanthropy or public subsidy, the Board retained power. Until after World War II every admission was approved by the Board. The Board made policy and hired a series of strong administrators with radical attitudes toward society and the delivery of medical care.

World War I ended American enthusiasm for Germany. In 1917 Jacob Schiff, on the advice of his daughter, stopped speaking German in public. Three years later he died and profound changes occurred. Siegfried Wachsmann, the physician who had overseen the 1912 move to the Bronx, resigned and the Board appointed a young, scientifically inclined, cardiologist, Ernst Boas. His father was the distinguished Franz Boas, who held the first chair of anthropology at Columbia University and more than anybody else established and shaped the discipline in the United States. The father brought a new outlook to anthropology. Instead of ranking peoples as savage or civilized, as inferior or superior, he saw them as equals, all struggling with the same problems of raising children, of establishing nurturing communities, all with much to learn from each other. His son saw patients as equal partners in the medical enterprise. He established a patients' council to help run Montefiore. One of the chapters in his text book on the care of the chronically ill was written by a patient. Franz Boas' two most famous students were Ruth Benedict and Margaret Mead. Ernst accepted large numbers of women as residents at Montefiore at a time when most American hospitals excluded female house staff.[12]

A product of German liberalism on both sides of the family, his mother's father a refugee from 1848, he well understood that the availability of medical care was, for more and more people, a political decision. He campaigned ceaselessly for better care for the chronically ill, most of whom in the 1920s were not in well run, well financed hospitals such as Montefiore. The lucky ones were at home, nursed by their families. The unlucky were in workhouses, poorhouses or county homes, where they received almost no med-

ical care or skilled nursing care, and often not even adequate food or shelter. Later in life he founded Physicians' Forum, an organization devoted to radical causes in medicine.

Boas was succeeded by a man whose prim exterior hid the heart of a revolutionary. Ephraim Michael Bluestone was unalterably opposed to the American norm of fee-for-service practice. With the support of a Board of Trustees that retained both its ancient power and an interest in the social purposes of the hospital, he was able to implement a series of programs that brought structural changes to the delivery of medicine. In 1933 he experimented with a full-time salaried clinical chairmanship which both provided support for a refugee from Berlin and established a new pattern for the delivery of care in voluntary hospitals. By the time he retired in 1951 all his clinical departments were run by salaried chairmen. In the meantime he had set up a hospital-based Home Care Department, a prepaid medical group practice that was part of the Health Insurance Plan of New York City, and the first Department of Social Medicine in any American hospital.

When the trustees selected a successor to Bluestone they chose the man who was running these programs. In doing that they made a statement about the kind of hospital they wanted.

Martin Cherkasky was chief executive officer for 30 years, implementing that social agenda. In the years during which American medicine raced triumphantly down the highway of high tech medicine, he took a different path. Montefiore took advantage of the new discoveries to deliver the best in scientific medicine. At the same time, Cherkasky and the Board of Trustees did not forget the original agenda. New programs brought better health care to the neglected: the Martin Luther King Junior Health Care Center in the wilderness of the South Bronx; health care for the prisoners on Rikers Island and the children at Spofford Juvenile Detention Center; community based health centers to care for new generations of immigrants; training programs to teach the old philosophy to new generations of physicians; affiliations with municipal hospitals. Montefiore remained a social instrument.

Much of the interest of the modern records lies in tracing the process by which this was accomplished. Programs are powered by philosophy backed by judicious allocations of resources. Montefiore bypassed the period during which most other voluntary hospitals were substantially supported by patients who paid their bills out of their own pockets. During Cherkasky's regime the financial basis of his hospital changed completely from dependence on philanthropy and public subsidy for the medically indigent to support from Blue Cross/Blue Shield, Medicaid and Medicare. Nationally, these funding

mechanisms paid the bills of individual patients and greatly increased the number of people with access to medical care. They also were the device which vastly augmented the money available to hospitals, allowing an enormous expansion of technology, of personnel and of programs in teaching, research and patient care. An extensive field for exploration by medical historians is a comparison of the various ways in which institutions used their increased financial resources and the directions taken by their expanded activities.

Another area for research is the relationship of hospitals to other institutions in the community. Many of Montefiore's ventures into social action activism depended on outside agencies for financial, bureaucratic or philosophical support. Several foundations, the Commonwealth Fund, the Milbank Memorial Fund and the Robert Wood Johnson Foundation, for instance, have a long history of collaboration with Montefiore. The City of New York and Montefiore have also had a long and complex history of cooperation. A city subsidy for the care of the medically indigent became an important item in the Home's budget before the turn of the century. Bluestone was a member of the committee that designed the Health Insurance Plan for Mayor Fiorella LaGuardia, and Montefiore was the only hospital willing to house and sponsor such a group. In the early 1960s it was the first voluntary hospital to enter into an affiliation contract with a municipal hospital, with far reaching consequences for the organization of health care delivery in the city. Pioneering programs in the medical care of prisoners were conducted under contract with and at the request of the city.

One of the most interesting of Montefiore's partnerships since World War II has been with the Albert Einstein College of Medicine. The usual relationship of a teaching hospital to a medical school is probably subservience. In this case, two independent, powerful bodies with antithetical attitudes to the purposes of medical education and practice attempted to work together because of geographic and communal bonds. The record of that often stormy, but also often productive, marriage illuminates many of the basic dilemmas of American medicine.

The pattern of decision making at Montefiore remained distinctly different from that at other hospitals. The Board of Trustees retained power and continued the tradition of appointing strong administrators with a highly developed sense of social needs. These chief executive officers in turn attracted and nurtured staffs of administrators who combined a high level of clinical skill with a commitment to social change sometimes developed on the job, often preceding their arrival at Montefiore. Since the hospital did not attract

a voluntary attending staff interested in admitting their own patients until after the growth of a strong central administration and the establishment of a system of full-time, salaried clinical chairmen and other physicians, the organized voluntary attending staff never achieved the degree of power that they enjoyed at other hospitals.

While the study of Montefiore history could have been conducted by an outside historian, the decision was made to set up an in-house position, a full-time salaried historian, who would also have the responsibility of collecting, sorting and cataloging the records. This, of necessity, entailed certain constraints on the activities of the historian. On the other hand, there were distinct advantages. The historian came to be seen as an integral part of the institution, available as a source of information and advice and as a participant in the research and teaching programs. Lectures to residents on the history of the hospital and of their own departments allowed them to gain not only the satisfaction of knowing something of their heritage but also some understanding of the mechanics of change. Publication of a history of the institution[13] led not only to the spread of a knowledge of that history but also to a lively debate about the interpretation of the facts and to the opening of further lines of investigation.

An understanding of its own history is useful to the ongoing functioning of any organization. An article in the *Harvard Business Review*, November–December, 1981,[14] described the benefits that a formal history program could bring to a company involved in private business. Those benefits also apply to Montefiore and to any hospital or public institution. The writer summarized the corporate applications of historical research as helpful in many areas: planning, management development, marketing, legal support and public affairs. Easy access to the historical record has frequently served an immediate practical need as when an agency of the State of New York questioned the exact meaning of the term "perpetual bed" as used in early bequests to the Home.

More important, a study of the history demonstrated a continuity of events, a cause and effect sequence. In a discipline that has changed as rapidly as has medicine in the last century and in a rapidly growing and changing institution such as Montefiore, adaptation to change can seem to be the most useful of survival skills. Recognition that there is a pattern and a philosophy apparent in all the twistings and turnings can provide the most ultimately productive of administrative skills, the ability to make all the day-to-day decisions and choices with an awareness of basic purpose.

The history of Montefiore is a part of social and medical history in a city

in which health care institutions have played an extraordinarily important role. Partly because it has always been a city of immigrants, New York City has provided many services that in other more settled communities would have been provided by family. Montefiore opened at the beginning of one of the eras of heaviest immigration. It was also the beginning of a great boom in hospital building. In that same decade 36 other hospitals opened in New York City.[15] Many of those institutions have since closed, their records lost forever. Many existing hospitals will, however, be celebrating centenaries in the next 10 or 20 years. The collection of their records and a serious consideration of their histories would be the most fitting kind of celebration.

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